Crisis Bed Development Work Group
July 28, 2006 9:00 a.m. – 11:00 a.m.
Clara Martin Center, Randolph, Vermont

Present:	Jeff Rothenberg, CMC Sandy Smith, CSAC John Stewart, RMHS Anne Donahue, Counterpoint Sheryl Bellman, HCHS (by phone)
Staff:	Judy Rosenstreich, VDH/DMH Cindy Thomas, VDH/DMH

Jeff recapped where the work group is:

- Ask the Emergency Services Directors to track people throughout September to assess the need for crisis bed programs.
- Continue discussions with CRT and Emergency Services directors, and with hospitals, on the development of the work group's recommendations.
- Recognize overlap of crisis beds program development with the issues before the Care Management Work Group.

ACUTE CARE MANAGERS' DATA ON VSH ADMISSIONS AND DISCHARGES

Cindy Thomas and Jim Farrell reviewed admission and discharge data of the Vermont State Hospital. Jeff requested this information to assess the potential of reducing inpatient days by improving the capacity and accessibility of crisis beds.

- Admissions data (for a recent 3-month period) was clear that admissions to VSH were necessary and could not have been diverted through utilization of a crisis bed program.
- Discharge data indicated that in the previous 6 months, there could have been 10 discharges if step-down beds (this level of capacity) were available. (This result is not linked to geography or to a specific number of step-down beds.)

Cindy suggested that the information appeared to confirm our thoughts at the outset of Futures planning, that a driver of the VSH census is increased length of stay (LOS) due to lack of housing options.

STATEWIDE INTEREST IN DEVELOPING CRISIS BEDS

Jeff reported that interest in developing crisis bed capacity is high among a number of designated agencies that he has heard from, including Northeast Kingdom Human Services, Northwestern Counseling and Support Services, Rutland Mental Health

Services, Counseling Service of Addison County, and his own agency, Clara Martin Center. All have said that they need crisis beds.

DISCUSSION OF PRINCIPLES FOR DEVELOPING NEW CRISIS BED CAPACITY

Jeff opened discussion of 12 core principles (program guidelines) of crisis bed programs for consideration by the work group:

1. voluntary: clients are admitted voluntarily
2. medical oversight provided daily
3. staff are specifically trained in:
    a) recovery
    b) dual diagnoses treatment
    c) family psycho education and support, and
    d) trauma-informed services
4. peer services component (yet to be clarified)
5. part of the larger care management system
6. need to be fully funded (current Medicaid and other insurances do not reimburse crisis bed services)
7. ensure that services are closer to a person's home
8. divert from hospital admission or shorten length of stay
9. facility has the right to decide, in the context of the care management system, who to accept for crisis diversion
10. beds open to the greater need of the system but are intended to divert from inpatient care or reduce length of stay as a post-hospitalization component
11. not limited to CRT clients
12. daily access to a psychiatrist

Work group members raised several comments and questions:

- A crisis bed program cannot function without next step resources.
- How can we balance providing services closer to home with the advantages of a facility that provides more therapeutic steps?
- Do some of the principles developed by the Inpatient Work Group also apply to crisis beds?
- Their voluntary nature does not mean that an individual can choose a particular crisis bed if one closer to home is available.
- As the existing, loose network of DA services and DA crisis beds is tied together in a more coherent way, crisis bed programs may be developed as a collaboration among DA's or through a consortium.
- Given the differences among existing crisis diversion programs, it may make sense to bring about greater consistency.
- Defining a crisis bed requires that we first define the care / service they are expected to provide.
- What are hospital observation beds and what type of beds may not be associated with a hospital?

Jeff later summarized and expanded upon the discussion of core principles, offering this summary:

Individual program choices: May a person exercise choice in the context of limited program availability? The voluntary nature of these programs does not mean that s/he can choose which crisis program to use based on a preference such as a smoking policy. In addition, to meet objectives, the program would have to be closest to a person's home.

Care management system: Crisis beds will be a component of the overall system for managing access and availability of acute care resources.

Peer services: The peer services component may be linked to Vermont Psychiatric Survivors (VPS).

Populations served: Crisis bed programs are intended for anyone who is clinically appropriate for this level of care; not just for clients of the CRT system. Therefore, we have to think programmatically about what is needed to serve a broader population.

Screeners' role: Screeners play a significant role in diversion recommendation.

Program size/capacity: Unless a program is associated with a hospital, you need 3-4 beds. A single-bed program could work if part of a hospital setting.

Daily psychiatric oversight: Given that not every client needs to see a psychiatrist every day, the goal of "daily psychiatric oversight" should be *as needed*.

Medical oversight: The level of nursing and staffing coverage has to be addressed.

HEALTH RESOURCES ALLOCATION PLAN (HRAP)

Jeff spoke of the statement of principles in HRAP, suggesting that the group consider incorporating these principles into the resource allocation program for crisis beds. He pointed out the extent to which the HRAP principles strengthen and substantiate our thinking about crisis bed programs. The group agreed.

The HRAP states, "The plan must include a statement of principles that reflect policies to be used in allocating resources and in establishing priorities for health care services." Judy will provide copies of the six principles (including the sub-principles), a four-page document from HRAP. The HRAP principles are:

1. Safety
2. Effectiveness
3. Patient-centeredness
4. Timeliness
5. Efficiency
6. Equity

IDEALS OF A CRISIS BED PROGRAM

Access to All Vermonters

Jeff suggested setting a goal to provide 90% of Vermonters access to a crisis bed within ½ hour and 100% of Vermonters access within 1 hour.

Peer Services Component

Jeff suggested that a core of trained peers could serve as a crisis de-escalation network. It would rely on an on-call system to bring in a peer support person, potentially reducing some involvement from emergency services. There is consumer interest in participating in this way.

SYSTEM GAPS IN NETWORK OF CRISIS BEDS

In a preliminary discussion of how the group may shape its report to the Advisory Committee, members defined the "ideal" as the actual need. Recognizing that it has taken 30 years to build the community mental health system, we are now in the process of identifying system gaps, prioritizing the gaps, and allocating resources for a transformed system. Embracing this Futures' vision, the group decided to identify and prioritize the gaps it sees in crisis bed services.

WORK GROUP TASKS

Judy: Designated Hospitals survey follow-up
Schedule meeting on observation beds with VAHHS (VT Assn. of Hospitals and Health Systems)
Give Crisis Beds minutes to Bob Pierattini, Tom Simpatico and Nick Emlen
Forward the statement of principles recommended by the Inpatient Work Group to assess their application to crisis beds.

Anne: Provide work group update at August meeting of Futures Advisory Committee.

Jeff: Request prospective client tracking by Emergency Services Directors to achieve full participation in survey

The meeting adjourned at 11:00 a.m. Next meeting: August 23, HCRS, Bellows Falls.

SUBMITTED BY: Judy Rosenstreich
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